Specialized programs for residents requiring behavioral interventions.

(a) General.

(1) Specialized programs for residents requiring behavioral interventions ("the program") shall mean a discrete unit with a planned combination of services with staffing, equipment and physical facilities designed to serve individuals whose severe behavior cannot be managed in a less restrictive setting. The program shall provide goal-directed, comprehensive and interdisciplinary services directed at attaining or maintaining the individual at the highest practicable level of physical, affective, behavioral and cognitive functioning.

(2) The program shall serve residents who are a danger to self or others and who display violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. This behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.

(3) The program shall be located in a nursing unit which is specifically designated for this purpose and physically separate from other facility residents. The unit shall be designed in accordance with the provisions as set forth in Subpart 713-2 of this Title.

(4) The facility shall have a written agreement with an inpatient psychiatric facility licensed under the Mental Hygiene Law to provide for inpatient admissions and consultative services as needed.

(5) In addition to the implementation of the quality assessment and assurance plan for this program as required by section 415.27 of this Part, the facility shall participate with the commissioner or his or her designee in a review of the program and resident outcomes. The factors to be reviewed shall include but not be limited to a review of admissions, the care and services provided, continued stays, and discharge planning. The facility shall furnish records, reports and data in a format as requested by the commissioner or his or her designee and shall make available for participation in the review, as necessary, members of the interdisciplinary resident care team.

(b) Admission.

(1) The facility shall develop written admission criteria which are applied to each prospective resident. As a minimum, for residents admitted to the program, there shall be documented evidence in the resident's medical record that:

(i) the resident's behavior is dangerous to him or herself or to others;

(ii) the resident's behavior has been assessed according to severity and intensity;

(iii) within 30 days prior to the date of application to the program, the resident has displayed:

(a) verbal aggression which constitutes a clear threat of violence towards others or self; or

(b) physical aggression which is assaultive or combative and causes or is likely to cause harm to others or self; or

(c) persistently regressive or socially inappropriate behavior which causes actual harm.

(iv) various alternative interventions have been tried and found to be unsuccessful;

(v) the resident cannot be managed in a less restrictive setting; and

(vi) the prospective resident has the ability to benefit from such a program.

(2) Prior to admission, the facility shall fully inform the resident and the resident's designated representative both orally and in writing about the program plan and the policies and procedures governing resident care in this unit. Such policies and procedures shall at a minimum include a statement that the resident's right to leave or be discharged from the program shall be consistent with the rights of other residents in the facility.

(c) Assessment and Care Planning.

(1) The interdisciplinary team shall have determined preliminary approaches and interventions to the severe behavior and recorded them in the resident care plan prior to admission to the unit.

(2) Each resident's care plan shall include care and services which are therapeutically beneficial for the resident and selected by the resident

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when able and as appropriate. The care plan shall be prepared by the interdisciplinary team, as described in section 415.11 of this Part, which shall include psychiatrist, psychologist, or social worker participation as appropriate to the needs of the resident.

(3) Based on the resident's response to therapeutic interventions, the care plan including the discharge plan shall be reviewed and modified, as needed, but at least once a month.

(d) Discharge.

(1) A proposed discharge plan shall be developed within 30 days of admission for each resident as part of the overall care plan and shall include input from all professionals caring for the resident, the resident and his or her family, as appropriate, and any outside agency or resource that will be involved with the resident following discharge.

(2) When the interdisciplinary team determines that discharge of a resident to another facility or community-based program is appropriate, a discharge plan shall be implemented which is designed to assist and support the resident, family and caregiver in the transition to the new setting. Program staff shall be available post-discharge to act as a continuing resource for the resident, family or caregiver.

(3) The resident shall be discharged to a less restrictive setting when he or she no longer meets the admission criteria for this program as stated in subdivision (b) of this section.

(4) A resident discharged to an acute care facility shall be accompanied by a member of the program's direct care staff during transfer. He or she shall be given priority readmission status to the program as his or her condition may warrant.

(5) There shall be a written transfer agreement with any nursing home of origin which allows for priority readmission to such transferring facility when a resident is capable of a safe discharge.

(e) Resident services and staffing requirements.

(1) The program shall consist of a variety of medical, behavioral, counseling, recreational, exercise, and other services to help the resident control or redirect his or her behavior through interventions carried out in a therapeutic environment provided on-site.

(2) There shall be dedicated staffing in sufficient numbers to provide for the direct services in the unit and to allow for small group activities and for one-on-one care.

(3) The unit shall be managed by a program coordinator who is a licensed or certified health care professional with previous formal education, training and experience in the administration of a program concerned with the care and management of individuals with severe behavioral problems. The program coordinator shall be responsible for the operation and oversight of the program. Other responsibilities of the program coordinator shall include:

(i) the planning for and coordination of direct care and services;

(ii) developing and implementing inservice and continuing education programs, in collaboration with the interdisciplinary team, for all staff in contact with or working with these residents;

(iii) participation in the facility's decisions regarding resident care and services that affect the operation of the unit; and

(iv) ensuring the development and implementation of a program plan and policies and procedures specific to this program.

(4) A physician who has specialized training and experience in the care of individuals with severe behavioral or neuropsychiatric conditions shall be responsible for the medical direction and medical oversight of this program and shall assist with the development and evaluation of policies and procedures governing the provision of medical services in this unit.

(5) A qualified specialist in psychiatry who has clinical experience in behavioral medicine and experience working with individuals who are neurologically impaired shall be available on staff or a consulting basis to the residents and to the program.

(6) A clinical psychologist with at least one year of training in neuropsychology shall be available on staff or a consulting basis to the residents and to the program.

(7) A social worker with experience associated with severe behavioral conditions shall be available either on staff or a consulting basis to work with the residents, staff and family as needed.

(8) Other than the program coordinator, there shall be at least one registered professional nurse deployed on each shift in this unit who has training and experience in caring for individuals with severe behaviors.

(9) A full-time therapeutic recreation specialist shall be responsible

for the therapeutic recreation program.

(10) The facility shall ensure that all staff assigned to the direct care of the residents have pertinent experience or have received training in the care and management of individuals with severe behaviors.

(11) The facility shall ensure that educational programs are conducted for staff not providing direct care but who come in contact with these residents on a regular basis such as housekeeping and dietary aides. The programs shall familiarize staff with the program and the residents.

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ate Setting and Financial Reporting for State and non-State agency perated Intermediate Care Facilities for the Developmentally Disabled. For the purpose of this section: "Provider" shall mean the individual, corporation, partnership or other organization to which the OMRDD has issued an operating certificate, to operate a facility, or a State owned developmental center and to which the New York State Department of Social Services has issued a Medicaid provider agreement for such facility. For the purpose of this section: "Facility" shall mean that program and site for which OMRDD has issued an operating certificate, to operate as an intermediate care facility for the developmentally disabled, or a developmental center which consists of institutional beds, including those beds in Small Residential Units operated by a Developmental Disabilities Services Office (DDSO), except those beds in Small Residential Units operated by a DDSO whose developmental center has closed or is scheduled to close, and for which the New York State Department of Social Services has issued a Medicaid provider agreement.

(a) Reporting Requirements

(1) Financial reports shall include the following:

(i) Budget Reports

(a) Each provider intending to operate a facility shall include budget information in its application to receive an operating certificate.

(b) The budget shall cover a 12-month period from July 1 to the following June for non-State operated facilities in Region I as defined in Section (c)(3)(v), and a 12-month period from January 1 to the following December 31 for non-State operated facilities in Regions II and III as defined in Section (c)(3)(v), unless another time frame is specified by the commissioner. For State operated facilities the budget shall cover a 12-month period from April 1 to the following March 31.

(ii) Cost Reports

(a) Each provider shall, on an annual basis, be required to submit a cost report for each certified facility.

(b) The cost report shall cover a 12-month period from July 1 to the following June 30, for non-State operated facilities in Region I, and a 12-month period from January 1 to the following December 31 for non-State operated facilities in Regions II and III, unless another time frame is specified by the commissioner. For State operated facilities the cost report shall cover a 12-month period from April 1 to the following March 31.

(c) Each cost report shall be forwarded so that it is received by OMRDD no later than 120 days after the last day of the period which it covers.

[(e)](d) Providers that operate non-State facilities both in Region I and Region II or III, may make [a one-time] an application to the commissioner to elect either a June 30 or December 31 reporting year end[.] to correspond to the reporting year of the geographic location of the primary program and/or administrative operations of the provider. Such application may be granted at the commissioner's discretion [to correspond to the reporting year of the geographic location of the primary program and/or administrative operations of the provider.] The selection and subsequent approval of the commissioner of a year-end shall mean that all OMRDD certified programs operated by that provider will be reported on that chosen fiscal cycle and year-end. In the absence of an application by the provider the commissioner shall designate either a June 30 or December 31 reporting year-end and fiscal cycle for all OMRDD certified programs operated by that provider. A provider whose reporting year-end and fiscal cycle have been designated by the commissioner may apply to the commissioner to be returned to either a June 30 or December 31 year-end and fiscal cycle to correspond to the reporting year of the geographic location of the primary program and/or administrative operations of the provider. The approval of this application by the commissioner shall mean that all OMRDD certified programs operated by that provider will be reported on that chosen fiscal cycle and year-end.

(iii) A facility providing day treatment services shall be required to identify in its submitted budget or cost report the actual expense attributable to the provision of day treatment services and the actual number of units of service associated with said expense.

(2) Statistical reporting requirements for facilities shall include but not be limited to the following:

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(i) Each provider shall submit with its annual cost report, statistical data relevant to program utilization. Such information shall include actual client days for the facility. If the day program is offered on-site, there shall be a separate reporting of the actual units of service as defined in Part 690 associated with such programming. This data shall correspond to the identical time period of the cost report.

(ii) Each provider shall upon the request of OMRDD, submit statistical data relevant to the administration and operation of the facility as determined by the Commissioner. Such reports shall be submitted within the timeframe(s) authorized in the request.

(iii) Each provider shall submit, with its cost report, a listing of the clients who were served during the period covered by the cost report.

(3) Requirements for certification of financial reports, related statistical information and financial report data:

(i) Each provider shall complete the required financial reports in accordance with generally accepted accounting principles, unless other principles are specified by the Commissioner.

(ii) Cost reports prepared for non-State operated facilities shall be certified for their compliance with §(a)(3)(i) by the provider's executive director or [agency] officer and by an independent licensed public accountant or certified public accountant who is not on the staff of the provider, on the staff of a program operated by the provider, and who has no financial interest, and is not an affiliate of, as defined in §(c)(10)(ix)(d) the program operated by the provider; and include a statement of the findings and opinion of the certified public accountant or licensed public accountant. Also incremental/decremental cost data submitted in accordance with §(c)(3)(iii)(b) and §(c)(4)(ii)(b), shall be certified for its compliance with §(a)(3)(i) by the provider's executive director or officer.

(iii) Budget reports from non-State operated facilities submitted in accordance with §(a)(1)(i)(a) shall be certified for their fair representation of anticipated expenditures by the provider's executive director or officer.

(4) Failure to file required financial and statistical reports

(i) The Commissioner may grant an extension of time of up to 30 days for filing the required reports if OMRDD receives a request for extension from the provider, at least 15 days prior to the due date. Such request for extension shall document in writing that the provider cannot file the report by the due date for reasons beyond its control, and shall include an explanation of such reasons.

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(ii) The Commissioner may grant an additional extension of 30 days if the provider applies for an extension in accordance with the procedure stated in §(a)(4)(i) above. The maximum allowable extension that may be granted shall not exceed 60 days in total unless the Commissioner, upon investigation, finds that failure to report is beyond the control of the provider and/or enforcement of the reporting timeframe requirements would jeopardize the facility's operation.

(iii) If a provider fails to file the required reports, on or before the due dates, taking into account any granted extensions, the Commissioner may at his discretion reduce the facility's existing rate, exclusive of State paid items, by five percent for a period beginning on the first day of the month following the due date of the required reports and continuing until the last day of the calendar month in which all the required reports are received.

(iv) The provider may ask for a hearing before the Commissioner requesting a stay of the imposition of a penalty for failure to report, providing the provider has made application requesting a time extension and the Commissioner has either rejected the application or failed to respond to that application within 10 days.

(v) In the event that the rate for a facility cannot be developed so that it will be effective on the first day of the rate period, due to the provider's not submitting the required reports by the due date, the average rate for facilities having similar operating characteristics, or the rate reduced by any existing five percent penalty in existence on the last day of the immediately proceeding rate period (i.e., the length of time as determined by the Commissioner that an approved rate is valid), whichever is lower, will be in effect until such time as OMRDD can develop a new rate.

(vi) When OMRDD develops a rate for a facility for which a rate was paid in accordance with §(a)(4)(v) above, the rate developed will be effective on the first day of the first month following OMRDD's receipt of the required report. The Commissioner shall, upon application by the provider within 60 days subsequent to submission of the delinquent report and based on his finding that there were reasonable grounds for the delay, make the rate retroactive to the beginning of the rate period in question.

(5) Requirements for the revision of financial reports shall include the following:

(i) In the event that OMRDD determines that the required reports are incomplete, inaccurate, incorrect or otherwise unacceptable, the provider shall have 30 days from the date of its receipt of notification to submit a revised report or additional data. For non-State operated facilities, such data or report shall be

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